

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/28/2010  
FORM APPROVED  
OMB NO. 0938-0391

45th 7/10/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445110	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/26/2010
NAME OF PROVIDER OR SUPPLIER  NHC HEALTHCARE, COOKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 815 SOUTH WALNUT AVENUE COOKEVILLE, TN 38501	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  An Annual Recertification and Complaint investigation #18023, #25501, were completed on May 24, through 26, 2010. No deficiencies were cited related to the complaint investigations under 42 CFR Part 483.13, Requirements for Long Term Care Facilities.	F 000	Allegation of compliance The Plan of Correction is submitted as required under State and Federal law. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determination is correct.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.  The facility must record and periodically update the address and phone number of the resident's	F 157	Begin POC F 157 1. Corrected actions accomplished for the resident(s) found to have been affected by the allegedly deficient practice. The physician was notified by the Director of Nursing on May 25, 2010, of the resident's blood sugar history, including the residents' recent readings. A new order was received to notify the physician for blood sugar reading less than 60 or greater than 400. 2. How we have identified other residents having the potential to be affected by the same practice and what corrective action has been taken. On May 25, 2010 the Director of Nursing oversaw a comprehensive review of all resident records and if not previously notified, the physician was notified of any blood sugar reading <60 or >400 or abnormal signs and symptoms of hyperglycemia or hypoglycemia. New orders were noted as needed.	05/25/2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

*JCS TONER*

*ADMINISTRATOR*

6/9/10

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	<p>Continued From page 1</p> <p>legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policy, and interview, the facility failed to notify the physician of low finger stick blood sugar (FSBS) levels and/or high FSBS for three residents (#2, #13, #10) of twenty-one sampled residents.</p> <p>The findings included:</p> <p>Resident #2 was admitted to the facility on December 11, 2007, with diagnoses including Diabetes Mellitus, Multiple Sclerosis, Pressure Ulcer and Neurogenic Bladder.</p> <p>Medical record review of the Physician's Recapitulation Orders For April and May of 2010, revealed, "...FSBS AC (before meals) and HS (at bedtime) ...Sliding scale insulin with Novolog SQ (subcutaneous injection) as follows: &lt;150=0 units; 151-200=2 units; 201-250=4 units; 251-300=6 units; 301-350=8 units; 351-400=10 units; &gt;400=12 units and call MD..."</p> <p>Medical record review of the Diabetic Monitoring Log revealed the resident had a FSBS of 44 on April 10, 2010, at 5:30 p.m., a FSBS of 56 on April 11, 2010, at 7:00 a.m., a FSBS of 55 on April 11, 2010, at 5:30 p.m., a FSBS of 54 on April 12, 2010, at 5:30 p.m., and a FSBS of 54 on May 1, 2010 at 11:00 a.m.</p> <p>Resident #13 was admitted to the facility on May 24, 2004, with diagnoses including Diabetes Mellitus, Diabetic Neuropathy, Alzheimers</p>	F 157	<p>3. The Measures we have put in place and systematic changes we have made to ensure that the practice does not recur.</p> <p>The following measures have been put in place and the following systematic changes have been made to ensure that the practice does not recur. On May 25, 2010 the Medical Director, Regional Nurse, and Director of Nursing updated the center's policies for "Insulin Administration" and "Notification of Physician" were updated to direct the Nursing staff to notify the physician when a resident's blood sugar is less than 60 and greater then 400, when the patient is exhibiting signs and symptoms of hyperglycemia or hypoglycemia or as directed by the resident's current physician order.</p> <p>On May 25, 2010 licensed nurses were in-serviced on the center's policies for "Insulin Administration" and "Notification of Physician". Specific emphasis was given during the in-service on the updated portions of the policies directing Nursing staff to notify the physician when a resident's blood sugar is less than 60 and greater then 400, when the patient is exhibiting signs and symptoms of hyperglycemia or hypoglycemia or as directed by the resident's current physician order.</p>		

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F 157	<p>Continued From page 2</p> <p>Disease, Hypertension, and Osteoporosis.</p> <p>Medical record review of the Physician's Recapitulation Orders for April and May of 2010, revealed "...FSBS AC (before meals) and HS (at bedtime) ...Sliding scale insulin with Novolog SQ (subcutaneous injection) as follows: &lt;150=0 units; 151-200=2 units; 201-250=4 units; 251-300=6 units; 301-350=8 units; 351-400=10 units; &gt;400=12 units and call MD..."</p> <p>Medical record review of the Diabetic Monitoring Log revealed the resident had a FSBS of 42 on April 2, 2010, at 4:20 a.m., a FSBS of 44 on April 8, 2010, at 1:20 a.m., and a FSBS of 56 on April 22, 2010, at 7:00 a.m.</p> <p>Review of facility policy Insulin Administration revealed "...5. Physician to be notified of blood sugars below 60 or above 200 unless there is a specific order addressing blood sugars outside these ranges or directing otherwise..."</p> <p>Interview with the DON (Director Of Nursing) in the DON office on May 25, 2010, at 3:00 p.m., confirmed the facility had failed to notify the physician of the low blood sugars.</p> <p>Resident #10 was admitted to the facility on September 8, 2005, with diagnoses including Diabetes, Peripheral Neuropathy, Cardiovascular Accident with Left-Sided Weakness, Cerebrovascular Disease, Arteriosclerotic Heart Disease and Hypertension.</p> <p>Medical record review of the resident's March, April and May 2010, Physician Recapitulation</p>	F 157	<p>4. Our corrective actions will be monitored to ensure the practice will not recur.</p> <p>The corrective actions will be monitored via quality assurance studies that will be overseen by our Director of Nurses. Beginning May 25, 2010 five current resident records with orders for blood sugar reading or a history of hyperglycemia or hypoglycemia will be reviewed daily for compliance with the nurse notifying the physician per policy or physician order. These monitors will be continued for 10 days, then weekly for 6 weeks. The results of the monitors will be reported to the Quality Assurance Committee and the monitors and in-service training will be continued as directed by the Quality Assurance Committee.</p> <p>End POC F157</p>		

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F 157	Continued From page 3  Orders revealed, "FSBS AC & HS (finger stick blood sugars before meals and at bedtime)" and "Sliding scale insulin with Novolog SQ as follows: < (less than) 180 = 0 units; 181-240 = 4 units; 241-300 = 6 units; 301-400 = 8 units; > (greater than) 400 = 10 units."  Medical record review of the resident's Diabetic Log dated April 2010, revealed a low FSBS of 56 on April 18, 2010, at 11:00 a.m. Medical record review of the resident's Diabetic Logs dated March 2010, and April 2010, revealed the following high FSBS: March 26, 2010, at 7:00 a.m., 423 and 11:00 a.m., 477; March 27, 2010, at 11:00 a.m., 471; March 28, 2010, at 8:00 p.m., 415; March 30, 2010, at 11:00 a.m., 484 and 5:00 p.m., 457; April 3, 2010, at 8:00 p.m., 431; April 7, 2010, at 5:00 p.m., 422; and April 22, 2010, at 5:00 p.m., 413.  Review of facility policy Insulin Administration revealed "...5. Physician to be notified of blood sugars below 60 or above 200 unless there is a specific order addressing blood sugars outside these ranges or directing otherwise..."  Interview with the DON in the Conference Room on May 25, 2010, at 10:30 a.m., confirmed the facility had failed to notify the physician of the low and high blood sugars.	F 157			
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE  An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.	F 176	Begin POC F 176 1. Corrected actions accomplished for the resident(s) found to have been affected by the allegedly deficient practice.		05/31/2010

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F 176	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure assessment for self-administration of medications was completed for one resident (#10) of twenty-one residents reviewed.</p> <p>The findings included:</p> <p>Resident #10 was admitted to the facility on September 8, 2005, with diagnoses including Cerebrovascular Accident, Peripheral Neuropathy, Depression, and Anxiety.</p> <p>Medical record review of a physician's order dated September 20, 2007, revealed the resident was to receive Estrace cream 0.01% applied to the urethra three times a week on Monday, Wednesday, and Friday.</p> <p>Observation of a medication pass on May 24, 2010, at 8:20 p.m., with RN #1 (Registered Nurse), revealed the RN entered the resident's room and administered oral medications to the resident, applied an ointment to the resident's cheeks, and left a plastic medicine cup with Estrace cream 0.01% setting on the resident's over bed table.</p> <p>Interview with RN #1 on May 24, 2010, at 8:40 p.m., on the 200 hall confirmed the Estrace cream was left on the resident's over bed table for the resident to self-administer when ready.</p> <p>Interview with the Director of Nursing on May 24, 2010, at 9:05 p.m., at the 200 hall nursing station, confirmed the resident had not been assessed for self-administration of medications and</p>	F 176	<p>On May 25, 2010 the Director of Nursing oversaw the following actions. The patient was assessed for the self administration of medications. During the assessment the patient expressed a desire to discontinue the use of the medication in question. The physician was notified and an order was received to discontinue the medication.</p> <p>2. How we have identified other residents having the potential to be affected by the same practice and what corrective action has been taken.</p> <p>On May 27, 2010 the Director of Nursing oversaw a comprehensive review of all resident records and all patients were assessed and educated for the self administration of medications.</p> <p>3. The Measures we have put in place and systematic changes we have made to ensure that the practice does not recur.</p> <p>On or before May 31, 2010 the Director of Nursing ensured that all nursing staff had been in-serviced on the Self Administration of Medication Policy and Procedures. Any patient who is self administering medication (s) will be assessed for the ability and educated on documentation of medication administration.</p> <p>4. Our corrective actions will be monitored to ensure the practice will not recur.</p> <p>The corrective actions will be monitored via quality assurance studies that will be overseen by the Director of Nurses.</p> <p>Beginning May 25, 2010 we will conduct studies for 6 weeks to ensure compliance with the Self Administration of Medication Policy and Procedures. The results of the monitors will be reported to the Quality Assurance Committee and the monitors and in-service training will be continued as directed by the Quality Assurance Committee.</p>		

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F 176	Continued From page 5 medications were not to be left in the resident's room.	F 176	End POC F176		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES  A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.  This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to place the call light within reach for three residents (#16, #17, #18) of twenty-one residents reviewed.  The findings included:  Resident #16 was admitted to the facility on April 24, 2003, with diagnoses including Dementia, Anemia and Congestive Heart Failure.  Medical record review of the comprehensive care plan dated May 22, 2010, revealed "Risk for Falls" and "keep call light within my reach."  Observation on May 24, 2010, at 6:10 p.m., revealed the resident in bed with the call light draped over a reclining chair near the bed and out of reach of the resident.  Interview with the Director of Nursing on May 26, 2010, at 9:15 a.m., in the Administrator's office confirmed the call light is to be within reach of the	F 246	Begin POC F246 1. Corrected actions accomplished for the resident(s) found to have been affected by the allegedly deficient practice. The Director of Nursing oversaw the following actions. We checked call lights on all halls to ensure that they were within reach of the patient 2. How we have identified other residents having the potential to be affected by the same practice and what corrective action has been taken. The Director of Nursing oversaw a comprehensive review of all residents to ensure that all call lights were within reach. In addition we conducted in-service training with all staff regarding the center's Call Light Policy and Procedure this training was completed on May 31, 2010.		05/31/2010

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F 246	<p>Continued From page 6 resident.</p> <p>Resident #17 was admitted to the facility on September 28, 2009, with diagnoses including Pulmonary Embolism, Anemia, and Dementia.</p> <p>Medical record review of the comprehensive care plan dated March 1, 2010, revealed "ADL's" (activities of daily living) and "Please keep my call light within my reach."</p> <p>Observation on May 24, 2010, at 6:15 p.m., revealed the resident in bed with the call light cord draped across the foot board of the bed and out of the resident's reach.</p> <p>Continued interview with the resident revealed the resident was unable to reach the cord and ask the surveyor to please move the cord near the resident's left side.</p> <p>Interview with the Director of Nursing on May 26, 2010, at 9:15 a.m., in the Administrator's office confirmed the call light is to be positioned within reach of the resident.</p> <p>Resident #18 was admitted to the facility on July 19, 2005 with diagnoses including Acute Renal Failure, Dementia, and Arthritis.</p> <p>Medical record review of the comprehensive care plan dated February 24, 2010, revealed "ADL's" and "please keep call light within my reach."</p> <p>Observation on May 24, 2010, at 6:20 p.m., revealed the resident in bed with the call light cord draped across the foot board of the bed and out</p>	F 246	<p>3. The Measures we have put in place and systematic changes we have made to ensure that the practice does not recur.</p> <p>The Director of Nursing ensured that all nursing staff had been in-serviced on the center's Call Light Policy and Procedure this training was completed on May 31, 2010.</p> <p>4. Our corrective actions will be monitored to ensure the practice will not recur.</p> <p>The corrective actions will be monitored via quality assurance studies that will be overseen by the Director of Nurses. Beginning May 31, 2010 five patients will be checked for 10 days for the availability of call lights. Then we will sample 5 patients for 6 weeks and report the findings to the Quality Assurance Committee. During the studies if a deficient practice is noticed it will corrected and staff education will be provided. The results of the monitors will be reported to the Quality Assurance Committee and the monitors and in-service training will be continued as directed by the Quality Assurance Committee.</p> <p>End POC F246</p>		

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F 246	Continued From page 7 of the resident's reach.  Interview with the Director of Nursing on May 26, 2010, at 9:15 a.m., in the Administrator's office confirmed the call light is to be positioned within reach of the resident.	F 246			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure a safety alarm was in place for one resident (#3) of twenty-one residents reviewed.  The findings included:  Resident #3 was admitted to the facility on July 11, 2006, with diagnoses including Dementia, Parkinson's Disease, Osteoarthritis, Glaucoma, and Weakness.  Medical record review of the Minimum Data Set (MDS) dated March 1, 2010, revealed the resident had short term memory problems, moderately impaired cognitive skills for daily decision making, and required assistance with most activities of daily living.	F 323	Begin POC F323 1. Corrected actions accomplished for the resident(s) found to have been affected by the allegedly deficient practice. The Director of Nursing and Falls Prevention Nurse oversaw the following actions. On May 26, 2010 a pressure pad was checked for placement on the bed of resident #3. 2. How we have identified other residents having the potential to be affected by the same practice and what corrective action has been taken. The Director of Nursing and Falls Prevention Nurse oversaw a comprehensive review of all residents to ensure that proper interventions (including pressure pads) were in place to reduce the risk of falling.		05/31/2010

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F 323	Continued From page 8 Medical record review of a Falls Risk Assessment dated March 2, 2010, revealed the resident was at high risk for falls.  Medical record review of the Care Plan dated March 25, 2010, revealed "...alarms after supper to remind me to call for help..."  Medical record review of a Post Falls Nursing Assessment dated May 17, 2010, 8:00 p.m., revealed "...Patient was found sitting on floor with call light in hand by bedside...was reaching for lotion on the bedside table when...slipped from bed to floor..."  Review of a facility fall investigation form dated May 17, 2010, revealed "...no alarms on when the incident occurred..."  Observation on May 24, 2010, at 8:15 p.m. revealed the resident in bed, the bed in the lowest position, pressure pad alarm on the bed and activated.  Interview with LPN (Licensed Practical Nurse) #1, on May 26, 2010, at 10:25 a.m., confirmed the resident did not have the pressure pad alarm in place at the time of the fall on May 17, 2010.	F 323	3. The Measures we have put in place and systematic changes we have made to ensure that the practice does not recur. On or before May 31, 2010 the Director of Nursing and Falls Prevention Nurse ensured that all nursing staff had been in-serviced on the center's Fall Prevention and Intervention Program this training was completed on May 31, 2010. 4. Our corrective actions will be monitored to ensure the practice will not recur. The corrective actions will be monitored via quality assurance studies that will be overseen by the Director of Nurses. Beginning May 31, 2010 five patients will be checked for 10 days to ensure the proper intervention (including pressure pads) is in place to reduce the risk of falling. Then we will sample 5 patients for 6 weeks and report the findings to the Quality Assurance Committee. During the studies if a deficient practice is noted it will corrected and staff education will be provided. The results of the monitors will be reported to the Quality Assurance Committee and the monitors and in-service training will be continued as directed by the Quality Assurance Committee. End POC F323		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431	Begin POC F431 1. Corrected actions accomplished for the resident(s) found to have been affected by the allegedly deficient practice. The Director of Nursing did oversee the following actions. Medication and Meds room were checked for expired medications and any expired medications were removed on May 26, 2010.		05/31/2010

JUN 10 2010

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/28/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>445110</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/26/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>NHC HEALTHCARE, COOKEVILLE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>815 SOUTH WALNUT AVENUE COOKEVILLE, TN 38501</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 431	<p>Continued From page 9</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure medications were dated when opened and failed to ensure expired biologicals were not available for resident use for one of four medication carts and one of two medication rooms.</p> <p>The findings included:</p> <p>Observation of the medication cart on the 300 hall on May 26, 2010, at 8:00 a.m., with LPN #1</p>	F 431	<p>All glucometers were checked for expired test strips and any expired test strips were removed on May 26, 2010. All liquid or powder medication were checked for open dates and new medications were obtained from our pharmacy if opened without a date. All insulins were checked for open dates and new insulin was obtained from our pharmacy if opened without a date. We contacted our laboratory provider and obtained current in date vacutainers. All actions listed above were completed on or before May 26, 2010.</p> <p>2. How we have identified other residents having the potential to be affected by the same practice and what corrective action has been taken.</p> <p>The Director of Nursing and Consultant Pharmacist oversee that all medications, are checked on a weekly basis to ensure compliance with open date policy and expiration date policy. All glucometer strips will be checked weekly for expiration dates.</p>		

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F 431	<p>Continued From page 10</p> <p>(Licensed Practical Nurse) revealed a drawer containing the following multiple stock medications, not dated when opened: Aspirin 325 mg 125 tablets, 1/3 full; Colace Stool Softener 100 tablets, 1/3 full; Tussin DM Sugar Free Cough medicine 4 ounces, 2/3 full; Aspirin 325 mg 100 tablets, 1/2 full; Enulose one pint, 1/3 full; Pepto 8 ounces, 1/2 full; Liquid Acetaminophen 16 ounces more than 1/2 full; Docusate 16 ounces, more than 1/2 full.</p> <p>Observation of a drawer on the cart revealed a glucometer kit (to check blood sugar) containing glucometer strips with an expiration date of March, 2010, and dated as opened May 25, 2010.</p> <p>Interview with LPN #1 on May 26, 2010, at 8:00 a.m., on the 300 hall confirmed the stock medications had not been dated when opened and the glucometer strips were expired and had been used for a resident's blood sugar checks.</p> <p>Observation of the medication room on the 300 and 400 hall on May 26, 2010, at 8:15 a.m., revealed the following expired biologicals and undated medications: Glucometer strips with an expiration date of March, 2010; Stomahesive (for ostomy bag changes) one ounce expired September, 2009; Hemocult (to check for blood in stool) 15 mL expired March, 2009; and, in the refrigerator, one Humulin-R insulin 1/4 full, not dated when opened.</p> <p>Interview with the wound care nurse on May 26, 2010, at 8:15 a.m., in the 300 and 400 hall medication room, confirmed the biologicals had expired and were available for resident use.</p>	F 431	<p>3. The Measures we have put in place and systematic changes we have made to ensure that the practice does not recur. The Director of Nursing ensured that all nursing staff had been in-serviced on the center's Medication storage policy, Open date policy and Expiration date policy this training was completed on May 31, 2010.</p> <p>4. Our corrective actions will be monitored to ensure the practice will not recur. The corrective actions will be monitored via quality assurance studies that will be overseen by the Director of Nurses. Beginning May 27, 2010 glucometer strips will be checked daily for ten days to ensure that no expired strips are in storage. Then we will monitor with random checks for six weeks. Beginning May 27, 2010 Medications (including insulin) will be checked for ten days to ensure compliance with open date policy. Then we will monitor with random checks for six weeks. Beginning May 27, 2010 Vacutainers will be checked for ten days to ensure compliance with expiration date policy. Then we will monitor with random checks for six weeks.</p> <p>During the studies if a deficient practice is noted it will corrected and staff education will be provided. The results of the monitors will be reported to the Quality Assurance Committee and the monitors and in-service training will be continued as directed by the Quality Assurance Committee.</p> <p>End POC F431</p>		

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F 431	Continued From page 11 Interview with the Director of Nursing (DON) on May 26, 2010, at 8:20 a.m., in the 300 and 400 hall medication room, confirmed the insulin had not been dated when opened.	F 431			
F 444 SS=D	Interview with the DON on May 26, 2010, at 8:40 a.m., confirmed stock medications and insulin are to be dated when opened. 483.65(b)(3) PREVENTING SPREAD OF INFECTION  The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy, the facility failed to ensure hand hygiene was performed between contact with residents during a medication pass.  The findings included:  Observation of a medication pass on May 24, 2010, at 8:10 p.m., revealed RN #1 (Registered Nurse) dispensed medications for resident #10 at the medication cart. Observation revealed a fire drill was called at 8:13 p.m., and RN #1 moved the medication cart down the hall, into a room, and assumed staff fire drill responsibilities including closing resident doors. Observation revealed, after the fire drill at 8:20 p.m., RN #1 brought the medication cart from a room down the hall to resident #10's room, and without performing hand hygiene, removed the dispensed	F 444	Begin POC F444 1. Corrected actions accomplished for the resident(s) found to have been affected by the allegedly deficient practice. The Director of Nursing oversaw the following actions. The nurse in question was in-serviced on proper hand-washing procedures during a medication pass. The nurse was then observed completing a medication pass using proper hand-washing procedure. 2. How we have identified other residents having the potential to be affected by the same practice and what corrective action has been taken. The Director of Nursing oversaw the following actions. All nursing staff were in-serviced on proper hand-washing procedures during a medication pass. The in-service training was completed by May 31, 2010.		05/31/2010

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F 444	<p>Continued From page 12</p> <p>medications from the drawer, entered the resident's room, donned gloves, and gave the resident a medicine cup of oral medications. Observation revealed RN #1 applied an ointment to the resident's cheeks, moved the resident's over bed table, removed the gloves, and exited the resident's room without performing hand hygiene. Observation revealed, RN #1 returned to the medication cart, and without performing hand hygiene, dispensed medications for the next resident across the hall. Observation revealed, without performing hand hygiene, RN #1 entered the next resident's room, administered the resident's medications, and touched multiple surfaces in the resident's room, including the bedrails. Observation revealed, without performing hand hygiene, RN #1 returned to the medication cart and dispensed medications for a third resident. Observation revealed, without performing hand hygiene, RN #1 entered the resident's room and administered the medications.</p> <p>Review of facility policy Handwashing revealed "...Wash hands before and after contact with each patient...and before and after removal of gloves..."</p> <p>Interview with RN #1 on May 26, 2010, at 8:40 p.m., on the 200 hall, confirmed the RN failed to perform hand hygiene before and after contact with residents and resident's personal items.</p>	F 444	<p>3. The Measures we have put in place and systematic changes we have made to ensure that the practice does not recur.</p> <p>The Director of Nursing ensured that all nursing staff had been in-serviced on the center's hand-washing procedure this training was completed on May 31, 2010.</p> <p>4. Our corrective actions will be monitored to ensure the practice will not recur.</p> <p>The corrective actions will be monitored via quality assurance studies that will be overseen by the Director of Nurses. Beginning May 31, 2010 a random nurse will be observed each day for 10 days to ensure that proper hand-washing techniques are being used during a medication pass. The same observation process will be conducted weekly for 6 weeks with one random nurse selected each week and findings will be reported to the Quality Assurance Committee. During the studies if a deficient practice is noted it will be corrected and staff education will be provided. The results of the monitors will be reported to the Quality Assurance Committee and the monitors and in-service training will be continued as directed by the Quality Assurance Committee.</p> <p>End POC F444</p>		

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